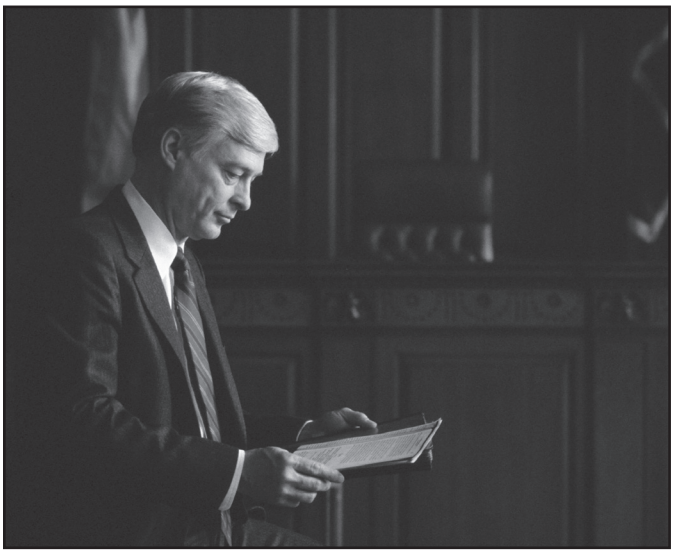
Section L
How to file an appeal for Medicare Part A, Part B and Part D and Medicare Advantage Plans



How to file an appeal for Medicare Part A, Part B and Part D and Medicare Advantage Plans (HMO, PPO, PFFS, etc.)

Your Medicare appeal rights

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan, a Medicare Advantage Plan (HMP, PPO, PFFS, etc.), or a Medicare prescription drug plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

Important reminders when filing an appeal

- The decision letter you receive at each level of appeal will explain additional appeal rights you may have, so you should read these letters carefully.
- Include documents that support your case as the decision will be based on document review. For example, you should include copies of your medical bill, copies of related MSN's or denial letters.
- Clearly explain why you disagree with the previous decision.
- Keep copies of all information sent as well as detailed notes of any communication dealing with the appeal process. Always create a paper trail.
- Coding errors do not need an appeal to be corrected. Check with your provider to make sure the bill was submitted correctly.
- You or your appointed representative may request an appeal. If you choose to appoint a representative, you must complete the CMS Appointment of Representative form (CMS-1696).

Medicare Part A appeal process

Hospitals and other providers issue Notice of Discharge and Medicare Appeal Rights which explain why the provider believes that Medicare will not pay a claim. This is not an official Medicare determination so you may ask the provider to get an official Medicare determination. The official Medicare determination can be appealed. To get an official Medicare determination the provider must file a claim on your behalf.

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge or your need for possible post-hospital, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

If a skilled nursing facility (SNF) decides that your care cannot be covered by Medicare, and you disagree, you can ask that the SNF file a claim with its Medicare intermediary. The process is known as demand billing. When the SNF submits the demand bill, the Medicare intermediary will make an official coverage determination. By the SNF submitting a demand bill, you protect your right to appeal the determination made by the Medicare Intermediary.

There are five levels to the appeal process:

1. Redetermination by the company that handles your Medicare claims

Your Medicare Summary Notice (MSN) tells you if Medicare has paid your medical claim or denied it. This is

the initial determination. If your medical claim is denied and you believe Medicare should have covered it, you may request a redetermination.

- A request for redetermination must be filed within 120 days of your receipt of the MSN.
- The redetermination must be filed with the company that handles Medicare claims and is indicated on the MSN.
- There is no minimum dollar amount that must be in question to request a redetermination.
- The company that handles your Medicare claims will send you a written decision within 60 days of receiving your request.

You can request a redetermination in one of two ways:

- You can follow the instructions on the back of your MSN.
- You can submit the "Medicare Redetermination Request Form" (CMS form 20027) along with a detailed letter that includes your name, your Medicare number, the service and/or items, for which a redetermination is being requested, an explanation of why you disagree with the initial determination, the dates of service and your signature or the signature of your appointed representative. If you have an appointed representative, you must include a completed Appointment of Representative form (CMS-1696).

However you choose to request a redetermination, you must send it to the Medicare contractor identified on your MSN and it is very important to attach ALL supporting documentation that you believe may help your case.

2. Reconsideration by a Qualified Independent Contractor (QIC)

If you are dissatisfied with the redetermination decision, you may request reconsideration. The reconsideration is made by a Qualified Independent Contractor (QIC) (i.e. Maximus, First Coast Service) that didn't take part in the previous redetermination.

- The request for reconsideration must be filed with the QIC stated on the redetermination within 180 days of your receipt of the redetermination.
- There is no minimum dollar amount that must be in question for you to request a reconsideration.
- The QIC will send you a written decision within 60 days of receiving your request.

You can request a reconsideration by submitting the "Medicare Reconsideration Request Form" (CMS form 20033) along with a detailed letter that includes your name, your Medicare number, the service and/or items for which a reconsideration is being requested, an explanation of why you disagree with the reconsideration determination, the dates of service, your signature or the signature of your appointment representative and the name of the company that handles your Medicare claims and made the redetermination decision. If you have an appointed representative, you must include a completed Appointment of Representative form (CMS-1696). You should send a copy of the Medicare Redetermination Notice and all other documentation that may help your case to the QIC identified on the notice.

It is very important to attach copies of prior decisions and ALL supporting documentation that you believe may help your case.

3. Hearing by an Administrative Law Judge (ALJ)

If you are dissatisfied with the QIC's reconsideration decision, you may appeal to an ALJ.

- The request for a hearing with an ALJ must be filed within 60 days of your receipt of the reconsideration decision.
- All claims in your appeal must satisfy a minimum dollar amount in question to get an ALJ hearing. In the reconsideration letter, the QIC will provide an estimate of whether your case satisfies this requirement. However, it is up to the ALJ to make the final decision.

- The ALJ will send you a written decision within 90 days of receiving your request.

You can request an Administrative Law Judge Hearing by following the instructions on the reconsideration letter sent to you by the QIC.

4. Review by the Medicare Appeals Council (MAC)

If you disagree with the ALJ's decision, you may file an appeal with the MAC.

- The request for MAC review must be submitted in writing within 60 days of the receipt of the ALJ's decision.
- There is no minimum dollar amount that must be in question for you to request MAC review.
- The MAC will send you a written decision within 90 days of getting your request.

You can request a Medicare Appeals Council review by following the instructions on the ALJ's decision.

5. Review by the federal court

If you disagree with the MAC's decision, you may file an appeal in federal court.

- You can ask the Federal Court to review your appeal if what you are asking the health plan for (services or equipment) meets the minimum dollar amount. Your MAC decision will state the minimum dollar amount.
- Your request must be filed in US District Court within 60 days of your receipt of the MAC's decision.

You should refer to the MAC's decision for instructions on requesting a Federal Court review.

Medicare Part B appeal process

There are five levels to the appeal process:

1. Redetermination by the company that handles your Medicare claims

Your Medicare Summary Notice (MSN) tells you if Medicare has paid your medical claim or denied it. This is the initial determination. If your medical claim is denied and you believe Medicare should have covered it, you may request a redetermination.

- A request for redetermination must be filed within 120 days of your receipt of the MSN.
- The redetermination must be filed with the company that handles Medicare claims and is indicated on the MSN.
- There is no minimum dollar amount that must be in question to request a redetermination.
- The company that handles your Medicare claims will send you a written decision within 60 days of receiving your request.

You can request a redetermination in one of two ways:

- You can follow the instructions on the back of your MSN.
- You can submit the "Medicare Redetermination Request Form" (CMS form 20027) along with a detailed letter that includes your name, your Medicare number, the service and/or items, for which a redetermination is being requested, an explanation of why you disagree with the initial determination, the dates of service and your signature or the signature of your appointed representative. If you have an appointed representative, you must include a completed Appointment of Representative form (CMS-1696).

However you choose to request a redetermination, you must send it to the Medicare contractor identified on

your MSN and it is very important to attach ALL supporting documentation that you believe may help your case.

2. Reconsideration by a Qualified Independent Contractor (QIC)

If you are dissatisfied with the redetermination decision, you may request reconsideration. The reconsideration is made by a Qualified Independent Contractor (QIC) (i.e. Maximus, First Coast Service) that didn't take part in the previous redetermination.

- The request for reconsideration must be filed with the QIC stated on the redetermination within 180 days of your receipt of the redetermination.
- There is no minimum dollar amount that must be in question for you to request a reconsideration.
- The QIC will send you a written decision within 60 days of receiving your request.

You can request a reconsideration by submitting the "Medicare Reconsideration Request Form" (CMS form 20033) along with a detailed letter that includes your name, your Medicare number, the service and/or items for which a reconsideration is being requested, an explanation of why you disagree with the reconsideration determination, the dates of service, your signature or the signature of your appointed representative and the name of the company that handles your Medicare claims and made the redetermination decision. If you have an appointed representative, you must include a completed Appointment of Representative form (CMS-1696). You should send a copy of the Medicare Redetermination Notice and all other documentation that may help your case to the QIC identified on the notice.

It is very important to attach copies of prior decisions and ALL supporting documentation that you believe may help your case.

3. Hearing by an Administrative Law Judge (ALJ)

If you are dissatisfied with the QIC's reconsideration decision, you may appeal to an ALJ.

a. The request for a hearing with an ALJ must be filed within 60 days of your receipt of the reconsideration decision.
b. All claims in your appeal must satisfy a minimum dollar amount in question to get an ALJ hearing. In the reconsideration letter, the QIC will provide an estimate of whether your case satisfies this requirement. However, it is up to the ALJ to make the final decision.
c. The ALJ will send you a written decision within 90 days of receiving your request.

You can request a Administrative Law Judge Hearing by following the instructions on the reconsideration letter sent to you by the QIC.

4. Review by the Medicare Appeals Council (MAC)

If you disagree with the ALJ's decision, you may file an appeal with the MAC.

a. The request for MAC review must be submitted in writing within 60 days of the receipt of the ALJ's decision.
b. There is no minimum dollar amount that must be in question for you to request MAC review.
c. The MAC will send you a written decision within 90 days of getting your request.

You can request a Medicare Appeals Council review by following the instructions on the ALJ's decision.

5. Review by the federal court

If you disagree with the MAC's decision, you may file an appeal in federal court.

a. You can ask the Federal Court to review your appeal if what you are asking the health plan for (services or equipment) meets the minimum dollar amount. Your MAC decision will state the minimum dollar amount.
b. Your request must be filed in US District Court within 60 days of your receipt of the MAC's decision.

You should refer to the MAC's decision for instructions on requesting Federal Court review.

Medicare Part B (late enrollment penalty) appeal process

Part B late penalty appeals, called redeterminations, must be filed with your local Social Security office using form SSA561-U2 and a written letter of explanation.

Your appeal must include your name, address, phone number, Medicare number, Medicare effective dates and a full explanation of why you are appealing the penalty. Include proof of prior coverage if applicable.

Medicare Part D (coverage issues) appeal process

Appeal rights under Medicare Prescription Drug Plans:

If you are in a Medicare prescription drug plan, you can appeal a plan sponsor's decision not to provide or pay for a Part D prescription drug that you believe the plan sponsor should provide or pay for. The word "provide" includes such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting. The Medicare prescription drug plan must tell you in writing how to request an appeal.

After you file an appeal, the plan sponsor will review its decision. If the plan sponsor does not decide in your favor, you can appeal the plan sponsor's decision to an independent organization that works for Medicare, not for the plan sponsor. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

When you join a Medicare drug plan, the plan will send you information about the plan's appeal procedures. Read this carefully and keep this information.

If you have a complaint about your Medicare drug plan that doesn't involve coverage or payment for a drug covered by the Medicare drug plan, you have the right to file a complaint with the plan. This is called a grievance. You should file your grievance within 60 days from the event that led to your complaint.

If you have coverage issues with your Medicare drug plan, you have the right to request a coverage determination from your plan. There are two types of requests for coverage determination, standard and expedited. Once your plan has received the request, it has 72 hours to notify you of its decision for a standard request and 24 hours for an expedited request. Your request will be expedited if your plan determines or your doctor tells your plan that your life or health will be seriously jeopardized by waiting for a standard decision.

For some types of coverage determinations exceptions, you will need supporting documentation/statement from your doctor explaining why you need the drug. You may also need this documentation/statement if you are requesting that your plan cover a drug that is not on the formulary list. Once your plan receives the

documentation/statement, its decision-making time period begins.

If the plan decides against you, you can appeal the decision. There are five levels of appeal available to you.

1. Redetermination (appeal through your plan)
   - You must request this appeal within 60 calendar days from the date of coverage determination.
   - You must file the request in writing, unless your plan accepts requests by phone.
   - Your written request must include CMS form 20027, "Request for Redetermination".
   - Your request will be expedited if your plan determines or your doctor tells your plan that your life or heath will be seriously jeopardized by waiting for a standard decision.
   - Once your plan receives your request, it has 7 days for a standard request and 72 hours for a expedited request to notify you of its decision.

2. Reconsideration by an Independent Review Entity (IRE)
   - You must make this request in writing to the IRE within 60 days of the date of the redetermination decision.
   - Your written request must also include CMS from 20033, "Request for Reconsideration."
   - Your request will be expedited if the IRE determines or your doctor tells the IRE that your life or heath will be seriously jeopardized by waiting for a standard decision.
   - Once the IRE receives your request, it has seven days for a standard request and 72 hours for a expedited request to notify you of its decision.

3. Hearing by an Administrative Law Judge (ALJ)
   - You must make this request in writing within 60 days of the date from the date of the notice of the IRE decision.
   - You must send your request to the entity specified in the IRE's reconsideration notice.
   - To receive and ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). The IRE's decision will include the amount.
   - No statutory time limit for processing.

4. Review by the Medicare Appeals Council (MAC)
   - You must make the request to the MAC, in writing, within 60 days from the date of the notice of the ALJ's decision.
   - No statutory time limit for processing.

5. Review by a federal court
   - You must make the request, in writing, within 60 days from the date of the notice of the MAC's decision.
   - You must send your request to the entity specified on MAC's decision notice.
   - To receive a review by the Federal Court, the projected value of your denied coverage must meet a minimum dollar amount. The MAC's decision will include the minimum dollar amount.

Medicare Part D (late enrollment penalty) appeal process

You have the right to appeal a late enrollment penalty (LEP). The LEP must be assessed before you can appeal. You will receive a letter from your plan telling you about the imposition of the LEP. This letter will explain the appeal process.

LEP appeals are called reconsiderations and must be filed with the Medicare Independent Review Entity (IRE)

within 60 days from the date on the letter you received from your plan informing you of your LEP. Appeals regarding LEP's are filed at different addresses depending upon whether the individual is enrolled in a prescription drug plan (PDP) or a Medicare Advantage Plan with prescription coverage (MA-PDP).

Your appeal must be requested in writing and include your name, address, phone number, Medicare number, Medicare effective dates and a full explanation of why you are appealing the LEP. Include proof of prior coverage if applicable.

Maximus is required to make a decision within 30 days of receiving the request. This decision is final and can not be appealed.

PDP: MAXIMUS Federal Services
Eastgate Square
50 Square Drive Suite 210
Victor, NY 14564
Fax: 585-425-5301

MA-PDP: MAXIMUS Federal Services
1040 First Avenue Suite 200
King of Prussia, PA 19406
Fax: 484-688-5601

Medicare Advantage Plans (HMO, PPO, PFFS) appeal process

Appeal rights under Medicare Advantage Plans (HMO, PPO, PFFS, etc.)

If you are in a Medicare Advantage Plan, you can file an appeal if your plan will not pay for, does not allow or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision.

The Medicare Advantage Plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

You have the right to file a complaint if you have concerns or problems with your plan. A complaint may be either a grievance or an appeal. You must file your complaint with your plan within 60 calendar days of the date of the event that led to your complaint.

There are five levels of appeal available to you:

1. Redetermination (appeal through your plan)
   - You must request this appeal within 60 calendar days from the date of coverage determination.
   - You must file the request in writing, unless your plan accepts requests by phone.
   - Your written request must include CMS form 20027, "Request for Redetermination."
   - Your request will be expedited if your plan determines or your doctor tells your plan that your life or heath will be seriously jeopardized by waiting for a standard decision.
   - Once your plan receives your request, it has seven days for a standard request and 72 hours for a expedited request to notify you of its decision.

2. Reconsideration by an independent review entity (IRE)
   - You must make this request in writing to the IRE within 60 days of the date of the redetermination decision.
   - Your written request must also include CMS from 20033, "Request for Reconsideration."
   - Your request will be expedited if the IRE determines or your doctor tells the IRE that your life or heath will be seriously jeopardized by waiting for a standard decision.
   - Once the IRE receives your request, it has seven days for a standard request and 72 hours for a expedited request to notify you of its decision.

3. Hearing by an Administrative Law Judge (ALJ)
   - You must make this request in writing within 60 days of the date from the date of the notice of the IRE decision.
   - You must send your request to the entity specified in the IRE's reconsideration notice.
   - To receive and ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). The IRE's decision will include the amount.
   - No statutory time limit for processing.

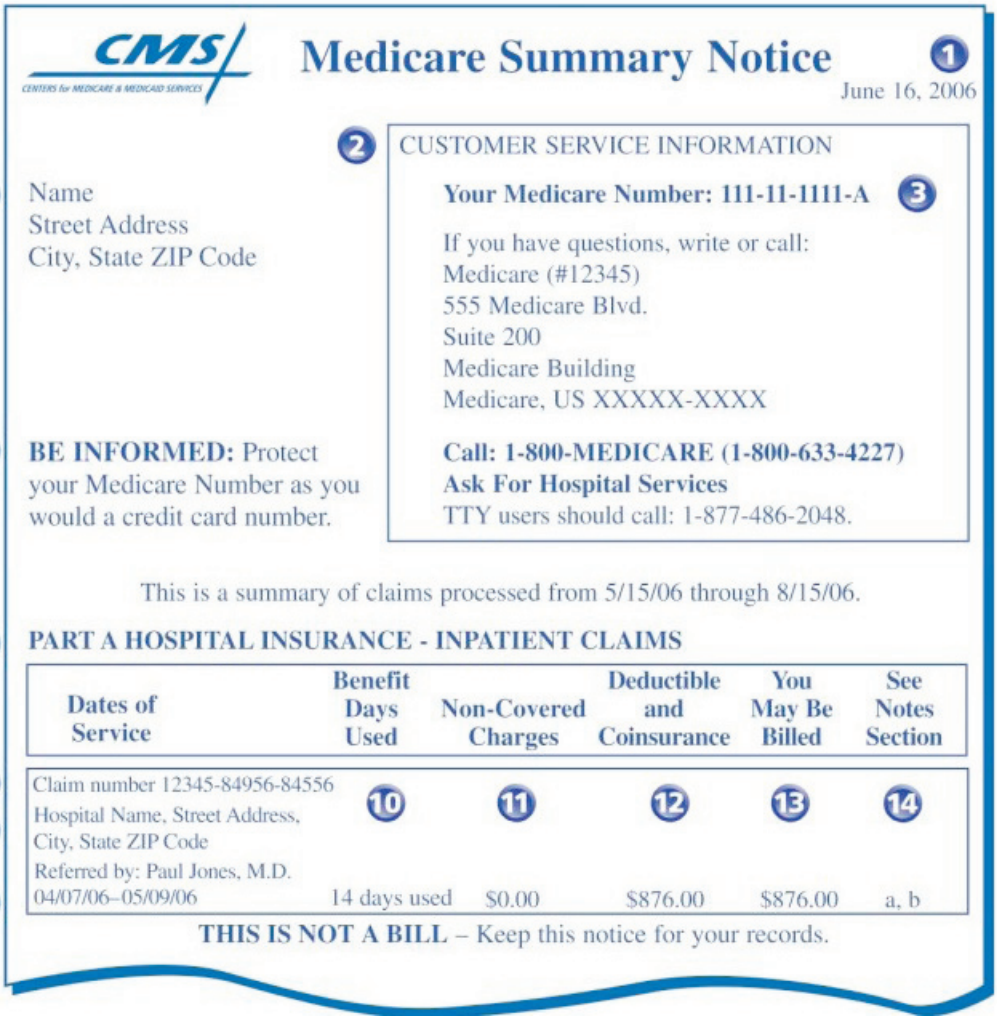
4. Review by the Medicare Appeals Council (MAC)
   - You must make the request to the MAC, in writing, within 60 days from the date of the notice of the ALJ's decision.
   - No statutory time limit for processing.

5. Review by a federal court
   - You must make the request, in writing, within 60 days from the date of the notice of the MAC's decision.
   - You must send your request to the entity specified on MAC's decision notice.

To receive a review by the Federal Court, the projected value of your denied coverage must meet a minimum dollar amount. The MAC's decision will include the amount.

How to read your Medicare Summary Notice (MSN)—Part A

Below is a sample Medicare Summary Notice (MSN) for Part A services and information on how to read it. The MSN is not a bill. Do not send money to Medicare or to the provider until you get a bill.



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice (1) June 16, 2006

(2) CUSTOMER SERVICE INFORMATION

(4) Name
Street Address
City, State ZIP Code

Your Medicare Number: 111-11-1111-A (3)

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

(5) **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Hospital Services
TTY users should call: 1-877-486-2048.

This is a summary of claims processed from 5/15/06 through 8/15/06.

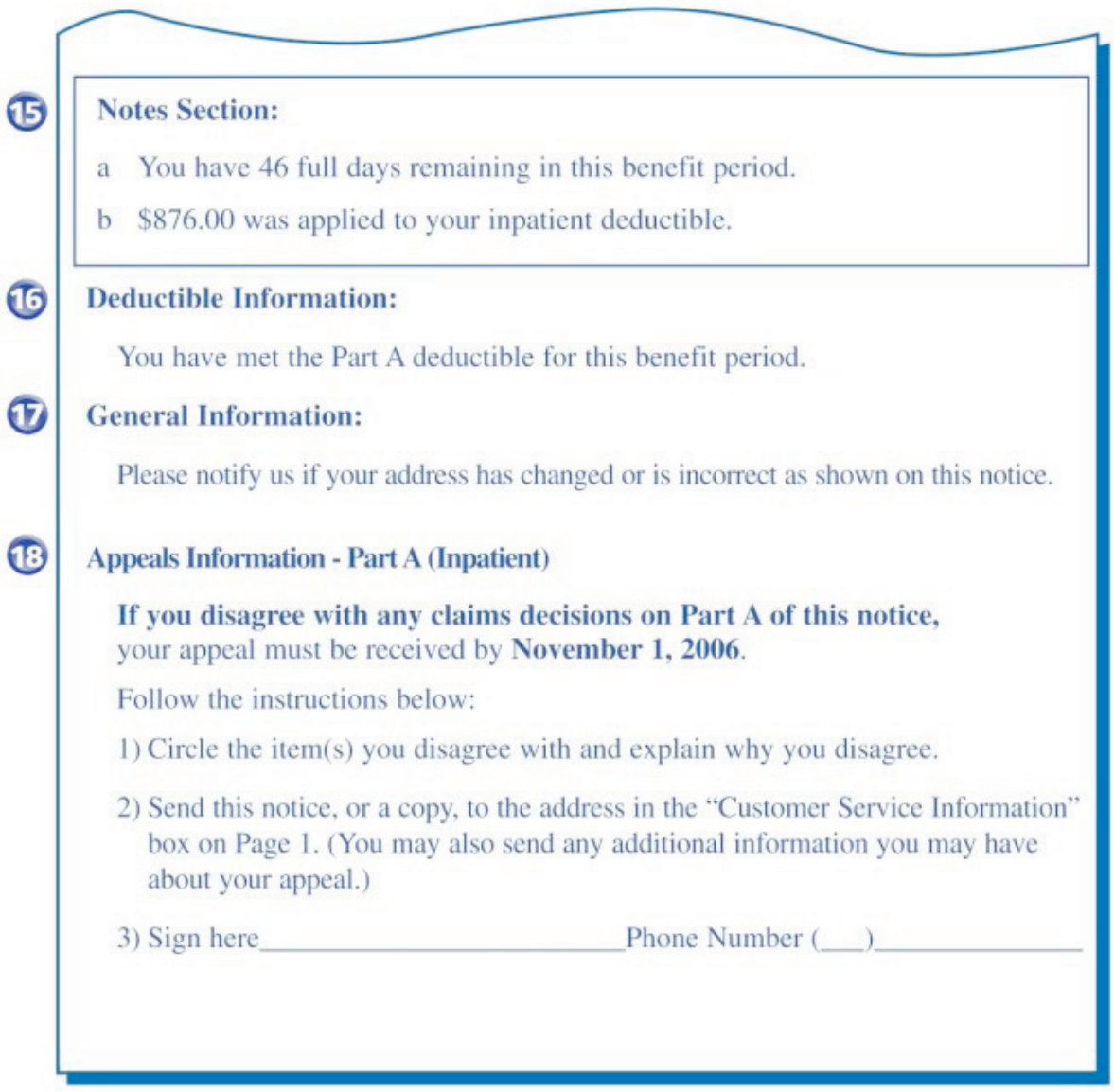
(6) **PART A HOSPITAL INSURANCE - INPATIENT CLAIMS**

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
(7) Claim number 12345-84956-84556 (8) Hospital Name, Street Address, City, State ZIP Code Referred by: Paul Jones, M.D. (9) 04/07/06–05/09/06	14 days used	(10) $0.00	(11) $876.00	(12) $876.00	(13) (14) a, b

THIS IS NOT A BILL – Keep this notice for your records.

1. Date: Date MSN was sent.
2. Customer service information: Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. Medicare number: The number on your Medicare card.
4. Name and address: If incorrect, contact the company listed in (2), and the Social Security Administration immediately.
5. Be informed: Messages about ways to protect yourself and Medicare from fraud and abuse.
6. Part A Hospital Insurance—inpatient claims: Type of service. See the back of MSN for additional information. (Please note: For outpatient services, this section is called "Part B Medical Insurance—outpatient facility claims.")
7. Dates of service: Dates service was provided. You may use these dates to compare with the dates shown on your hospital bill.
8. Claim number: Number that identifies this specific claim.
9. Benefit days used: Shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods. (Please note: For outpatient services, this column is called "Amount Charged.")
10. Non-covered charges: Shows the charges for services denied or excluded by the Medicare program for which you may be billed.
11. Deductible and coinsurance: The amount applied to your deductible and coinsurance.

12. You may be billed: The total amount the provider may bill you, including deductibles, coinsurance and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.
13. See notes section: If letter appears, refer to (15) for explanation.
14. Provider's name and address: Facility's name and billing address. The referring doctor's name will also be shown. The address shown is the billing address, which may be different from where you receive the service(s).



15 **Notes Section:**

a You have 46 full days remaining in this benefit period.

b $876.00 was applied to your inpatient deductible.

16 **Deductible Information:**

You have met the Part A deductible for this benefit period.

17 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

18 **Appeals Information - Part A (Inpatient)**

If you disagree with any claims decisions on Part A of this notice, your appeal must be received by **November 1, 2006**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

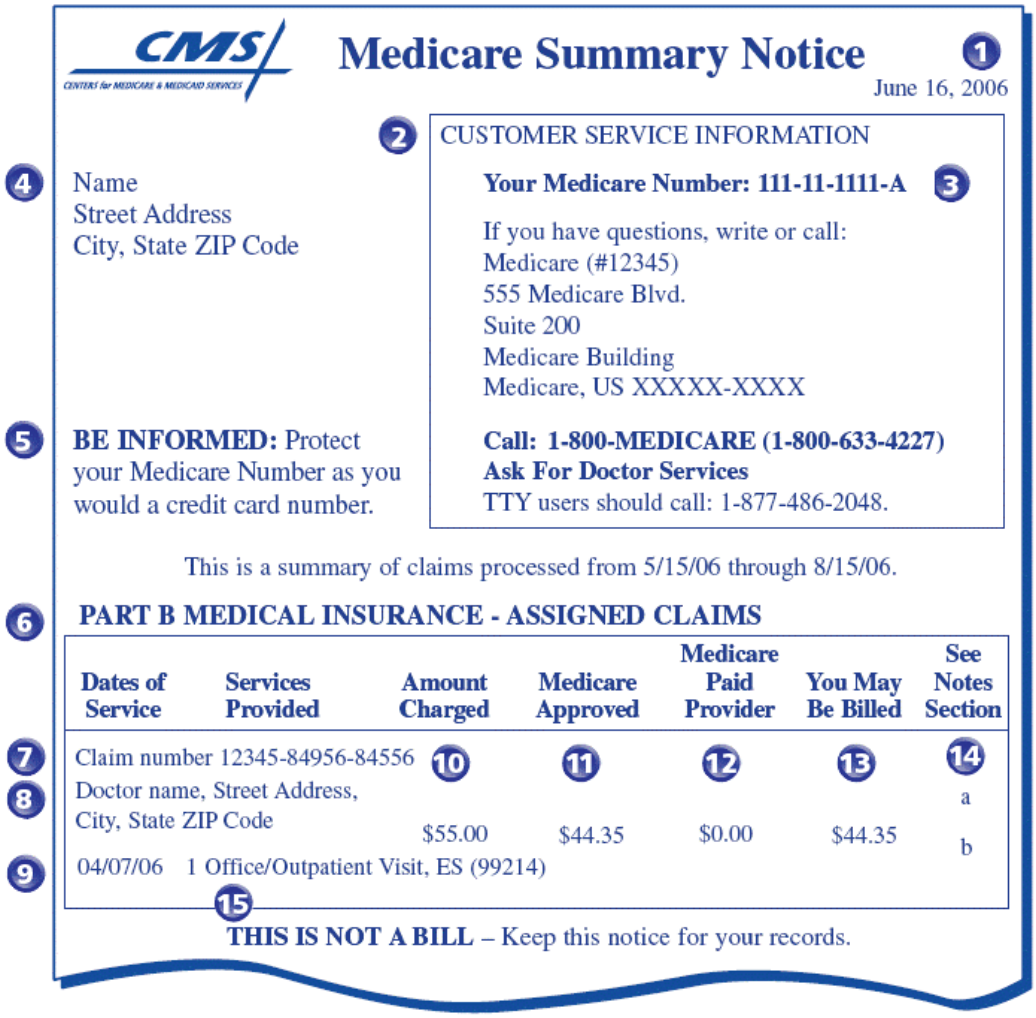
2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here_____Phone Number (___)_____

15. Notes section: Explains letters in (13) for more detailed information about your claim.
16. Deductible information: How much of your deductible you have met for the benefit period.
17. General information: Important Medicare news and information.
18. Appeals information: How and when to request an appeal.

How to read your Medicare Summary Notice (MSN)—Part B

Below is a sample Medicare Summary Notice (MSN) for Part B services and information on how to read it. The MSN is not a bill. Do not send money to Medicare or to the provider until you get a bill.



CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice (1) June 16, 2006

(2) CUSTOMER SERVICE INFORMATION

(4) Name
Street Address
City, State ZIP Code

Your Medicare Number: 111-11-1111-A (3)

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

(5) **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Doctor Services
TTY users should call: 1-877-486-2048.

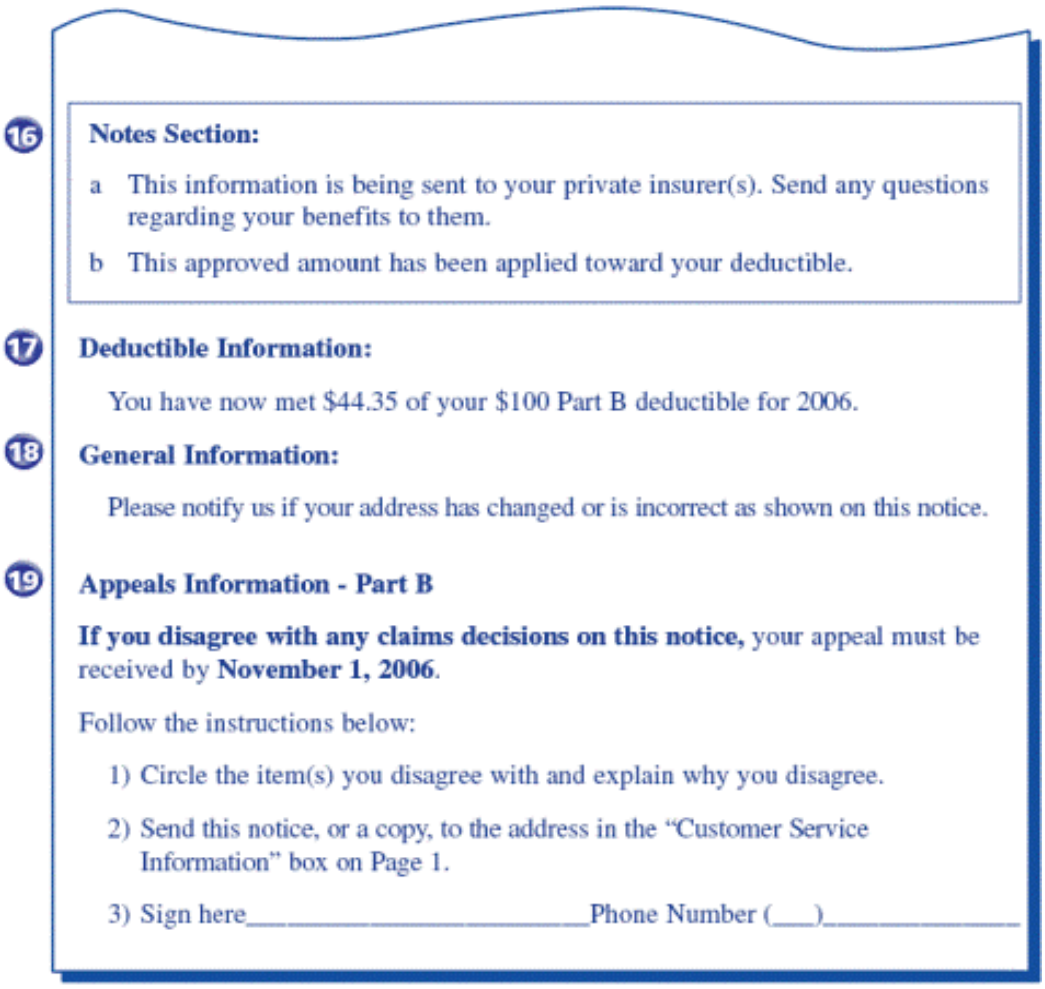
This is a summary of claims processed from 5/15/06 through 8/15/06.

(6) **PART B MEDICAL INSURANCE - ASSIGNED CLAIMS**

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
(7) Claim number 12345-84956-84556		(10)	(11)	(12)	(13)	(14)
(8) Doctor name, Street Address, City, State ZIP Code		$55.00	$44.35	$0.00	$44.35	a
(9) 04/07/06	1 Office/Outpatient Visit, ES (99214)					b

(15) **THIS IS NOT A BILL** – Keep this notice for your records.

1. Date: Date MSN was sent.
2. Customer service information: Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. Medicare number: The number on your Medicare card.
4. Name and address: If incorrect, contact the company listed in (2), and the Social Security Administration immediately.
5.Be informed: Messages about ways to protect yourself and Medicare from fraud and abuse.
6. Part B medical insurance—assigned claims: Type of service. See the back of MSN for information about assignment. (Please note: For unassigned services, this section is called “Part B Medical Insurance—unassigned claims.”)
7. Claim number: Number that identifies this specific claim.
8. Provider’s name and address: Doctor (may show clinic, group, and/or referring doctor) or provider’s name and billing address. The referring doctor’s name may also be shown if the service was ordered or referred by another doctor. The address shown is the billing address, which may be different from where you received the services.



16 **Notes Section:**

a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

b This approved amount has been applied toward your deductible.

17 **Deductible Information:**

You have now met $44.35 of your $100 Part B deductible for 2006.

18 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

19 **Appeals Information - Part B**

If you disagree with any claims decisions on this notice, your appeal must be received by **November 1, 2006**.

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here_____Phone Number (___)_____

9. Dates of service: Date service or supply was received. You may use these dates to compare with the dates shown on the bill you receive from your doctor.
10. Amount charged: Amount the provider billed Medicare.
11. Medicare approved: Amount Medicare approves for this service or supply.
12. Medicare paid provider: Amount Medicare paid to the provider. (Please note: For unassigned services, this column is called "Medicare Paid You.")
13. You may be billed: The total amount the provider may bill you, including deductibles, coinsurance and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.
14. See notes section: If letter appears, refer to (16) for explanation.
15. This is not a bill: This is not a bill.
16. Notes section: Explains letters in (14) for more detailed information about your claim.
17. Deductible information: How much of your yearly deductible you have met.
18. General information: Important Medicare news and information.
19. Appeals information: How and when to request an appeal.